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In This Number

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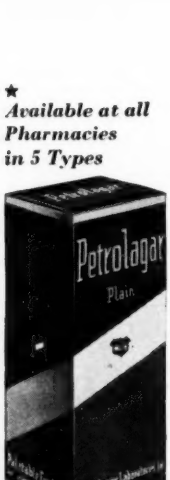

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THE RHODE ISLAND MEDICAL JOURNAL

VOLUME XXIII FEBRUARY, 1940 NUMBER 2

A STATE HOSPITAL PHYSICIAN LOOKS AT HEALTH IN RHODE ISLAND

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A concept of the individual which divides him into two arbitrary divisions physical and mental does not adequately convey the picture of man as the physician should see him. Admittedly our knowledge of biology and the behavioral processes of the individual is not sufficiently advanced yet to enable us always to correlate those behavioral processes that we call "thinking" and other behavioral processes that we think of as physiological. It would seem, however, that if we are ever to fathom the mechanics of mentation, we must think of them in terms of physiological function or dysfunction, as the case may be.

The particular aspects of health in Rhode Island that I would like to dwell on are those which are conventionally grouped under the heading of mental health. In reflecting on the opportunity which Dr. Messinger has given me to address you tonight, I felt very definitely that now was an opportune time to draw to the attention of the profession as represented by the members of the Providence Medical Association the fact that the outlook and facilities for dealing with mental health in this state have changed a good deal in the past few years. In order better to appreciate the significance of the changes and the present situation, I believe one should consider the background as it existed in this state approximately one hundred years ago, and as the medical profession viewed this type of illness at that time.

In the latter years of the eighteenth century, Pinel in France risked his professional reputation when he advocated different care and management and attitudes toward those suffering from mental illness. He was considered foolhardy by his professional colleagues of that day when he stated that he intended to strike off the chains and shackles and other means of mechanical restraint from patients at the Bicetre. Not only was he considered foolhardy, but almost a menace, in his radical departure from the conventional thinking of those days. It is a matter of record in medical history now that this was successful. Patients did not react when they had freedom from mechanical restraint as had been anticipated. On the other hand their behavior improved to such a degree that from then to the present time progressive thought in this field of medicine has taught, fostered and preached that restraint of this and other types should be avoided wherever possible. About the same time in England the Society of Friends being extremely dissatisfied with the management of mental patients current in English asylums of that day, decided that they would erect an institution which would be operated on a different philosophy and by different techniques. By subscription taken up in their own society, they raised sufficient funds to begin the construction of the York Retreat at York, England. William Tuke, an eminent physician of the Quaker persuasion, was chosen as the first superintendent. One of the fundamental principles underlying the operation of this hospital since its inception was the abolition of mechanical restraint, and this attitude and philosophy inspired other progressive developments in the care and management of these sick people during the remainder of the nineteenth century.

Let me now review very briefly the progress and advancement in the United States during this same period. The beginning of the nineteenth century saw only four institutions devoted to the care of the mentally ill in the whole country, and of these only one had been built by a governmental authority. These early institutions were located in Philadelphia (1752), Williamsburg, Virginia (1773), New York (1791), Baltimore (1797). In 1817,

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An address given at the Annual Meeting of the Providence Medical Association, January 9, 1940.

the Society of Friends in Philadelphia opened a second hospital in that city modeled on the lines of the York Retreat. In New England a year later the McLean Hospital was opened at Somerville, Massachusetts. In 1824, the Hartford Retreat, and in 1830, the asylum at Worcester, which is now the Worcester State Hospital was opened for the reception of patients. All these institutions were actuated in their treatment by the new scientific and humane ideas inaugurated by Pinel and Tuke. In Rhode Island, the situation was particularly interesting and revolved about the names of certain individuals who are now historical in the psychiatric world. The first mention of insanity in the enactments of the Rhode Island General Assembly was in 1725, when a statute was enacted whereby the towns on the Rhode Island mainland were empowered to build a house of correction for vagrants and to keep mad persons in. In 1742, the care of the insane and imbeciles was given over to the town councils. The opening of the Dexter Asylum in 1828 offered some slight alleviation in the conditions surrounding the care of the mentally ill of the City of Providence. Only a very small proportion however could be housed. To be exact, in 1842, twenty-six persons in Dexter Asylum were reported as being insane and properly housed. In 1841, a distinguished citizen of the state, Nicholas Brown, in a codicil to his last will and testament, made among other provisions the following:

"I do hereby set apart and give and bequeath the sum of $30,000 toward the erection or endowment of an insane or lunatic hospital or retreat for the insane, or by whatever other name it may be called, to be located in Providence or its vicinity." An additional quotation from Nicholas Brown's will is worth recording on account of the sentiment expressed and the language of expression. Referring to this lunatic hospital, it is stated: "That unhappy portion of our fellow beings who are by the visitation of Providence deprived of their reason may find a safe retreat and be provided whatever may be most conducive to their comfort and to their restoration to a sound state of mind." Pursuant to the provisions of this bequest, a charter was granted in January, 1844, by the General Assembly to the "Rhode Island Asylum for the Insane." A few months later, in March of the same year, Cyrus Butler, a prosperous merchant of the Providence community gave the sum of $40,000 to the erection and endowment of the institution previously mentioned, provided that a like sum should be obtained from other sources. By November of that year, this had been accomplished, and at the meeting of the corporation of this institution the name was changed to "Butler Hospital for the Insane," and the following year the trustees purchased a tract of land of one hundred and fourteen acres, where Butler Hospital now stands, and proceeded to erect a suitable building. All this was not accomplished without assistance, and the names of Thomas G. Hazard of this state and Dorothea Dix of Massachusetts appear frequently in the records.

Dorothea Dix, a remarkable woman, interested in those problems of social welfare which were so obviously in need of attention during this period, was introduced to the need of the mentally ill by a distinguished trio of Massachusetts physicians, Woodward of Worcester, Bell of McLean, and Butler of the Lunatic Asylum of Boston. These men influenced her thinking and inoculated her with an attitude and a familiarity with details of the problem which were largely responsible for her work in this field of health. Miss Dix by her personal efforts, her humanitarian appeals to logic, and unanswerable arguments was instrumental in interesting Cyrus Butler in this philanthropy.

Butler Hospital was fortunate in having as its first superintendent Dr. Isaac Ray, a distinguished physician, a leader, and a man of literary ability, who by his teaching and his writing did much to advance the care of the mentally ill not only in this state but in the country at large. Dr. Ray wrote authoritatively on medical jurisprudence, particularly with respect to those of unsound mind. In 1863 he published a volume entitled "Mental Hygiene" and appears to be the first on record to use this term. In this century, about thirty-two years ago, the term was re-invented and applied to a national committee which has been responsible for progressive developments in this field of community health during the last thirty years. A noteworthy event in the history of health in the state occurred in June, 1879, when the American Association of Asylum Superintendents met in Providence. This was nine years after the first patient had been received at what is now the State Hospital for Mental Diseases at Howard. In the Providence Journal of June 12th of that year, and also in the "Manufacturers' and Farmers' Journal" of the same date there is an interesting account of the proceedings of this meeting, and also by coin-

cidence on the same date the Rhode Island Medical Society held its annual meeting and invited delegates from the Asylum Superintendents to attend. Visits were paid to the Butler Hospital and to what is now the State Hospital and which was at that time called "The State Asylum for the Insane at the State Farm." This institution was administered by the Board of State Charities and Correction. It is interesting to note that at this meeting Dr. Ray presented a paper, he having then retired to Philadelphia, after an active life at Butler, and of the five points made in his paper the fifth, which I quote, reads as follows:

"During the last fifty years cerebral affections, of which insanity is only an incident, have been steadily increasing, thus diminishing the proportion of recoveries." One could use the same language exactly with reference to the situation in some of its aspects today. Due to the enlarged expectancy of life, there are more and more persons living in the age bracket of 55 — 70 years than there were twenty, or even ten, years ago. The natural processes of old age, the pathology and neurology of old age continue as they have in the past and we have no remedy for these processes. Cerebral arteriosclerosis is, if anything, more prevalent in terms of percentage incidence, and again, we have no remedy. As a consequence of these two circumstances, there is an absolute and a percentage increase in the admissions of this class of patient to the state hospitals throughout the country. Requirements for the proper housing and care of these elderly people in mental hospitals are increasing from year to year. On account of the physical incapacity consequent on this type of illness, the demand on physicians, the demand for nursing care and housing of a type adequate to deal with these cases is a matter of very considerable concern to mental hospital administrators. It is also a matter of concern to the taxpayer, as such cases require a type of housing and a type of care which is expensive. By reason of age it is not to be expected that this increasing group of patients can be occupied either for their own benefit or for the benefit of the hospital. Economic conditions throughout the country at large and in this state in particular have fostered the admission of elderly people to public institutions. These patients constitute a problem to which the medical profession should devote an effort to work out a solution. You have had in this state for almost one hundred years exceptional facilities for the mentally ill who were self-sufficient economically, and while necessary care was never withheld from those requiring it if they could be housed, a large number of the mentally ill in the state could not avail themselves of the facilities of Butler Hospital. Within the last ten years the City of Providence has adequately provided for those resident in Providence a department of the Charles V. Chapin Hospital for care and observation of borderline and acutely ill patients. Despite the efforts of many valiant physicians and others interested in health and welfare, the State Hospital until three years ago ran a neck and neck race with the institution at Little Rock, Arkansas, for the reputation of being the most overcrowded mental hospital in the United States. Due to the efforts of past and present members of our own society and laymen who were interested in this field in both private and public life, we now have facilities at the State Hospital which are as adequate and modern as any in the United States, or, for that matter, as far as my knowledge goes, anywhere in the world. Certainly this applies to the English speaking world. I do not believe that one can surpass anywhere the facilities available for the mental health needs of the community for all classes that exist in this state at the present time. Let me briefly enumerate:

The Emma Pendleton Bradley Home in East Providence, for children suffering from nervous and neurological conditions, conduct and emotional disorders; the Chapin Hospital with its psychiatric department; the Butler Hospital; and the State Hospital, and in addition the Out-Patient Department at the Rhode Island Hospital. I am not speaking now of the problem of mental deficiency but am confining my remarks strictly to those classified as mentally ill in mild or severe degree. With the out-patient and community clinics operated in conjunction with these institutions and the assistance which is available from specialists in private practice of their profession in the City of Providence and other parts of the state, it is possible to obtain the highest standard of care and attention in this field.

If I might crave your indulgence for a few moments, I would now like to devote a few remarks to the State Hospital.

It is an institution which you all support by your taxes. Progressive thinkers in the medical world today view institutions such as the State Hospital

as an integral part of the public health program of the people. It cannot and should not be divorced from this point of view. It should make a contribution to professional thinking about health without which medicine cannot accomplish the goal that is set for it. Medical thinking in the last twenty-five years has gradually veered from the viewpoint of specific infecting agents or traumatizing agents to a consideration of the individual in whom these infecting and traumatizing agents are acting. The progress in medicine in the next generation from my point of view is going to be in large measure dependent on the understanding of the individual as a whole and not on the agency which has descended on him and produced abnormal tissue behavior. The State Hospital at the present time has approximately 2800 patients. In the two years preceding July 1, 1939, the increase in the patient population was 336, an average of 168 patients per year. The staff presently concerned in the care and management of these patients now numbers approximately 535 persons. The invested money in plant is approximately $10,000,000. The operating yearly expense is approximately $1,000,000. A very real danger exists in your minds and in the minds of the public about this institution. The remark is very frequently made to me, "Now you have adequate accommodations, and the number of new buildings should see you with a safe margin for some time to come." Allow me here and now to correct this impression. If the rate of increase in the patient population proceeds as it has done in the last two years, then by January 1st, 1941, we will again be faced with the beginning of overcrowding. I do not think it is necessary to enlarge on to this audience the evils attendant on an overcrowded situation in a state mental hospital. The State Hospital four years ago was *so* overcrowded that it required entire duplication of plant in order to provide minimal housing facilities for the population it had at that time. This is why we are now faced with the necessity of thinking about the future and its requirements. I believe that the increase should not continue at the rate of the last two years. Since the first of August the patient census has been reduced approximately 50, but this is not an indicator by which to gauge the future. We will however have to provide within two years for at least 150 additional patients if we are to maintain adequate housing for those requiring accommodations. Let me dwell for a few moments on the community relations of the Hospital.

I mentioned a little earlier in this talk the question of community clinics which are operated from the Hospital by the staff of the Hospital. These clinics can operate for the benefit of the public health, but they can only operate in that respect when they are organized and set up around health facilities and in accordance with practices prevailing in the health field. It is not the purpose or the intent of these clinics to compete with members of the medical profession engaged in the private practice of their profession. At the present time new patients seen at these clinics must be referred by a physician, if a physician is available. If at any time they have had a private family physician, he is consulted before the patient is seen by a clinic physician. This does not necessarily apply when the only reason for seeking the clinic's advice is to obtain a psychometric estimation as to the basic intelligence as gauged by available tests. The Hospital administration will insist on a firm adherence to this practice. There are, of course, a small number of patients who come to the clinics from outlying districts where a physician is not readily available, and where the financial situation is such that the patient is not able to consult a physician. In these cases the clinic will function. But even in these cases, if there is any history of a family physician in the past, that physician will be consulted about the clinic's acceptance of the patient and will be given a report of what the clinic does or does not do for the patient. I know from past experience in places other than Rhode Island that misunderstanding has grown up and been fostered by the conduct of clinics of this sort. I am extremely anxious and on guard that no such situation shall continue so long as it is my responsibility to operate these clinics. As I stated earlier this evening, the mental health of the individual is not a thing apart from his general health. All the integral mechanics surrounding the treatment of these cases should be handled in exactly the same way in which they would be handled in case of an ordinary illness. I am of the opinion that all clinics for whatever form of illness they may have been set up should be conducted in this way. They are conducted in this way in Great Britain.

A few words about another aspect of community relations. I think I am not trespassing when I say that all the institutions dealing with the problem of mental illness in the State of Rhode Island are anxious that the physicians of the state should be

familiar with the care available, how that care is rendered, and to whom it is rendered. Their doors are open at all times and they invite your inspection. They provide a type of care with which you should be familiar. The same in somewhat different measure holds true so far as the public is concerned. Any member of the community who shows an intelligent intellectual curiosity is welcome at any time to any of the public or private institutions of the state. I think it is a matter of regret that some of your institutions dealing with Mental Health in Rhode Island are far better known, even in foreign countries, than they are in our own state.

To proceed to another aspect of this health problem, let me dwell for a moment on what we are trying to do. The effort in mental health today revolves essentially around activities which can be grouped under the one word "Education." We are trying to educate our patients as to ways and means of coping more adequately with the difficulties of life to which they have succumbed. We are trying to educate the nurses and attendants who are directly concerned in the personal care of patients. We are trying to educate workmen, tradesmen and artisans who are employed in the utilities of the Hospital in the role that they can and should play in the rehabilitation of the mental patient. We are interested in training professional personnel; among others, the medical personnel. I am glad to be able to tell you that in the State of Rhode Island at the present time it is now possible for the young medical graduate to obtain foundation training for the field of psychiatry and neurology which is unexcelled, in my opinion, anywhere in the United States. An arrangement has been effected between the State Hospital, Butler Hospital, Bradley Home, Brown University and Providence College for an educational program with a unified goal. A diversified training is available which will give any young physician proper preparaton in these specialties. In addition to the institutions already mentioned others are being asked to participate and contribute according to the field in which they are operating. A two-year residency program has been worked out, utilizing clinical material and educational facilities which are available here in the state. This training will be available to suitable candidates. Ten of these residencies will be available on July 1 of this year and succeeding years. Institutions of medical learning in nearby centers are assisting, particularly in the field of neuropathology, in the development of this program.

In internal medicine and surgery, certain medicaments and mechanical appliances are the therapeutic tools. In this field the therapeutic tools used in the treatment of patients are human beings. If we are to get the best of treatment and care for the mentally ill, then we must educate the individual engaged in personal attendance on patients. The therapeutic goals can be achieved in no other way. This central theme of education in the field of mental health is in my view a fundamental necessity if we are to achieve the therapeutic results which we know are possible. In no other way can a health program be set up and be as fruitful as our present knowledge demands that it should be. I am firmly of the opinion that here in Rhode Island this can be done, and that with cooperation and assistance it will be done, and will be done successfully. A broad program of this sort is worthy of your support. May I even go farther and say that as physicians you are bound to encourage it and use its results and add them to your own therapeutic armamentarium. The story of medical progress in this state and in this city is written in the record for everyone to see, and to me the visible proof that you are receptive of the ideas prevailing in this particular branch of medical science is offered by the opportunity you have given me tonight to address you.

DENTAL PROBLEMS OF INTEREST TO THE MEDICAL MAN

RAYMOND L. WEBSTER, D.M.D.
155 ANGELL STREET, PROVIDENCE

It gives me a great deal of pleasure, not only personally but as a member of the dental profession, to sit in with you, so to speak, to discuss some of our problems. The matter which I will discuss is medico-dental relationship. Following this discussion, I have a few slides to show you of recent findings of growth and development. A few years ago, by virtue of the difference of training, medicine and dentistry were very far apart. Since the scientific world has accepted the fact that diseases of the mouth and disorders of the teeth are grave sources of danger to the general health, medicine and dentistry have been brought closer together.

Vice-president of the Rhode Island State Dental Society.
Chief of Orthodontic Staff of the Joseph Samuels Dental Clinic for Children, of the Rhode Island Hospital.
Read before the Providence Medical Association, June 5, 1939.

The late Charles H. Mayo made the following statement: "Talking of the interdependence of medicine and dentistry is like talking of the interdependence of medicine and surgery or medicine and obstetrics. The practice of medicine includes dentistry, and dentistry is a special branch of medicine." This interdependence is much in evidence in the hospitals where medical and dental members of the staff are brought together to discuss their problems. Even there, from a dental standpoint at least, some improvement is possible. I refer to the complete dental examination, with a detailed report of the findings from such, as part of the physical examination of the patients.

We learn from the Mayo Clinic, which serves in a little different capacity than our city hospitals, that their dental diagnosis is as much a part of their service to patients as is diagnosis in the practice of dermatology, roentgenology, ophthalmology, and other specialties. The dental section is managed by three dentists, as other sections are managed by three or four physicians. These doctors of dentistry attend medical conferences and meetings, address physicians on subjects of interest, and contribute to the unity of purpose as do doctors of medicine.

To improve the medico-dental relations in hospitals, the American College of Dentists in their Annual Convocation of July 1937 made these recommendations: *First*—Encourage hospitals to establish dental service as a part of hospitalization. We have this to a minimum degree which might be increased. Rhode Island Hospital and St. Josephs Hospital have one dental intern each. *Second* — Urge dentists to seek appointments to hospital staffs. We have this in the house staffs but there is ample opportunity in the Out-patient Department, as at the Samuels Dental Clinic, for much more service from visiting dentists. *Third* — Urge each dental school to include in its curriculum for senior students, hospital routine and organization, and bedside dental service, including regular dental procedures. *Fourth* — That there be a standard record form for hospital dental service.

For the medical schools the recommendation has been made that some part of the curriculum of the medical students be given over to dentists, to educate them in dental problems and dental care. The importance of the condition of temporary and unerupted permanent teeth should be stressed. Dietary control of dental caries and other dental conditions should be emphasized. A physician should discuss mineral metabolism in relation to dental conditions and put the responsibility of much future dental disease squarely on the shoulders of these future physicians. There may be some disagreement about the field into which the last mentioned subject falls, because dentists have been driven largely by necessity to supervise it themselves. They should not prescribe medications in dietary deficiencies. It is not in their field. They have not been trained for it.

For the past twenty-five years dentistry has been carrying out most intensive and cooperative research, embracing the fields of chemistry, nutrition, bacteriology, metabolism and biology. Dentistry is no longer considered just a mechanical art. Teeth have surpassed the rank and standing of mechanical appliances, serving the dual purpose of mastication and adornment. It is now known that teeth, like bones, are dependent, as far as architecture is concerned, on minerals and vitamins, as well as on extraneous elements.

The dentist of today is being taught to develop a broader view of his duties to his patient than that encompassing only repair of the ravages of dental caries, and the extraction of teeth or their restorations. He must view the oral cavity as an integral part of a very complex body, always keeping in mind that complete functional activity depends on complete systemic integrity. He must recognize the fact that any departure from the normal in the mouth may be the cause, the effect or the symptom of systemic or organic disease in other parts of the body. The health of the patient must always be his first consideration.

The dentist who recognizes this responsibility, may at times, find oral conditions that point to the possibility of systemic disease which should receive medical care. It is not his part to make diagnosis in such cases, but he can at least suggest a medical examination and so aid in early recognition of the condition present.

Many a dental patient, because he feels in apparent good health, does not feel that periodic dental x-ray examinations are necessary. When his joints become disturbing, when he has a sinus-involvement, when he finds his heart is not functioning properly, his first move is naturally to see the family physician. The physician is able to apply his medical knowledge and experience to interpretation of the family history and the patient's personal history. He has a full knowledge of the

disease from which the patient is suffering and has made a comprehensive physical examination, which should include the other fields in which foci of infection can develop. Should not this include a complete dental examination with a detailed report to the physician suggesting the dental history and results of clinical and radiodontic examinations with the dentist's deductions therefrom? Diagnosis arrived at in this manner should be as nearly accurate as present day knowledge permits.

You will recall Dental Health Week, which we had in connection with our Annual State Dental Meeting, last January. This was an educational project in which we stressed prevention. Prevention is the one and only way that we can lighten the financial burden of disease, and, to that end, our greatest energy should be directed. In the attempt to stem the tide of dental disease by skilful restorations, we must admit that we have failed. Not only have we failed, but in our struggle to perfect our methods, we have created and devised such skilful scientific time-consuming technics that the cost of dentistry is becoming prohibitive to the masses. Prevention is the cheapest and yet the best service that we can give the public, and for that reason, should occupy a more important — yes, the most important place — in dental education and practice. Had we been more closely associated with medicine in the past, our progress in this most important branch of practice would have been much more rapid.

In this problem of prevention we call upon our medical brothers to help us, especially the obstetrician and the pediatrician. Despite all the dental education that is given the public today, some parents still believe that dental care is necessary only for permanent, fully developed teeth. As long as this situation exists, the responsibility for sound teeth belongs in a large degree to the physician. The tooth replaced by a bridge at the age of thirty years was a pulpless tooth at twenty years. The pulpless tooth at twenty years was a decayed tooth at ten years. The decayed molar at ten years erupted into the mouth at six years of age but was being formed at birth. At the moment of birth, several years before the mother takes her child to the dentist, the chewing surfaces of the permanent molars are forming. The materials needed for building sound teeth before the birth of a child must be present in the mother's blood in sufficient quantity and suitable form. Statistics show that 60% of the mal-occlusion of children's teeth is directly traceable to the early loss of decidous teeth through decay. These observations indicate the crying need for more dental care for children.

We also call upon the rhinologist, as well as the endocrinologist. Recently I read a report by a physician in which he stated that orthodontic problems arising because of disturbances in growth of the face were often found in individuals with clinical and subclinical allergy. He further stated that in addition to those disturbances in growth produced by allergy, there is an interference with the utilization of vitamins and other substances, especially minerals, so that the entire body, including the jaw, is mineralized. I was especially interested in his further stating that this accounts for some of the difficulties encountered in getting fixation of teeth after they are moved about by orthodontic procedures.

We have right here in our City the most ideal and unique possibility for a closer association between medical and dental men. I refer to the Joseph Samuels Dental Clinic of the Rhode Island Hospital. In this modernly equipped institution, we have facilities for teaching clinics, research laboratory, and a large auditorium in which joint meetings could be held.

For many years at our Annual State Dental Society Meetings we have gained much information from papers read by medical men and we stand ready at all times to reciprocate.

In summarizing my remarks, may I say, first, that the dentist should have a reasonable medical background, considerably more than even the present dental student obtains in spite of the marked advance dental education has made along these lines in recent years; secondly, that the physician know sufficient dentistry to understand dental points of views and values, considerably more than students receive in the medical education of today; thirdly, that ethics never be forgotten and good fellowship always prevail.

Medical and dental science, medical and dental service, advancing together, expecting each other's assistance in all phases of activity, will ensure the utmost in professional growth, opportunity and accomplishment. When such medico-dental relations are fulfilled, the patient should be fairly sure of sane and logical decisions from the consultation of competent, experienced practitioners.

THE RHODE ISLAND MEDICAL JOURNAL
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HOW TO JOIN THE RHODE ISLAND MEDICAL SOCIETY

Every member of the Providence Medical Association, the Pawtucket Medical Association, the Woonsocket District Medical Society, the Kent County Medical Society, the Newport Medical Society, and the Washington County Medical Society is eligible for membership in the Rhode Island Medical Society, without examination. To join the State Society it is only necessary for a member of one of the district societies to fill out the application blank which can be found in the advertising section of the JOURNAL and send it to the Secretary of the Rhode Island Medical Society, Medical Library Building, 106 Francis Street, Providence. Physicians who are prevented from joining a district society by reason of geographical location may be elected to membership in the State Society by majority vote of the members present at a regular meeting.

In addition to the usual functions of state medical societies, the Rhode Island Medical Society owns and operates the Rhode Island Medical Library. The Medical Library has a collection of more than 30,000 bound volumes, comprising a complete file of periodicals and many volumes of monetary value and of historical interest. Because of lack of funds, the collection is sadly lacking in recent medical works, having only those which are obtained through the book review department of THE RHODE ISLAND MEDICAL JOURNAL and an occasional gift from other sources. Members of the State Society each pay annual dues of ten dollars, three-quarters of which is at present required for the support of the Medical Library. This amount is sufficient for running expenses and the upkeep of the Library Building with no provision for the addition of new books.

While use of the library is freely offered to any member of the medical profession, guests should appreciate the fact that the Medical Library Building and its collection of volumes is supported by the money paid as dues by those who have joined the State Society. Too large a proportion of the physicians of Rhode Island are shirking an evident duty by their failure to support the State Medical Society. Join now, before it is too late to lend your support for this current year.

GROUP HEALTH

Much has been said and is being said about the controversy between the American Medical Association and Group Health Association, Inc.

It is of course gratifying that an indictment against the American Medical Association has been ruled invalid. The whole affair is a nasty business emanating with the odor of incrimination and recrimination. But after all, what is the true significance of the ruling? It is but a step in a legal battle which takes into consideration legal technicalities without due consideration of the medical and social problems that are at stake and which are in fact, the only merits on which the case should be decided. It is not a victory of principles, it is a victory of unimportant legal quibbling which merely tends to show that in the eyes of the law the medical profession is not a trade, and that the plaintiffs' charges were "vague, indefinite and uncertain,"—unimportant even if of academic interest to the lawyer.

The important question is does contract practice necessarily work in an unethical manner to the detriment either of the people or the profession? There is little doubt that the present status of medical practice with all its specialization brings

forth many financial problems to patient and physician alike. To solve these problems, a certian amount of experimentation is necessary. Many such experiments are being tried in the form of group practice and contract practice throughout the country. These have been studied by well constituted authorities and in certain aspects appear to be advantageous and not necessarily unethical. However, such practice can be made almost certainly unethical by making it highly undesirable for the worthy of the profession to enter into it. That is what we tend to do when we deprive physicians of their usual privileges and brand them as enemies of the people for even attempting it. True, it may not be successful, but our present system is by no means perfect and it is not without the realm of possibility that in the proper hands, a very urgent need may be served by some contract system. Let us not kill the spirit of research in social problems any more than in medical problems. If we don't like the methods that some doctors use, let us promptly develop a system of our own before an extra-medical group does it for us and coerces us to countenance it.

PROVIDENCE MEDICAL ASSOCIATION

December Meeting

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, December 4, 1939. The meeting was called to order by the President, Dr. H. C. Messinger, at 8:35 P. M. The minutes of the preceding meeting were read by the Secretary and were accepted as read.

The Secretary reported a communication to the executive office from Dr. Olin West, Secretary of the American Medical Association, in answer to an inquiry regarding the National Physicians' Committee for the Extension of Medical Service. Dr. West stated that "the National Physicians' Committee for the Extension of Medical Service has been organized by a group of outstanding physicians who are very definitely opposed to the regimentation of medicine and who wish to do all that they can to prevent developments that may lead to that undesirable end. It is also my understanding that the members of that group wholeheartedly support the policies of the organized medical profession in the United States. The National Physicians' Committee for the Extension of Medical Service is not officially affiliated with the American Medical Association but is, as stated above, an entirely independent group. I am informed that a number of those who are actively interested in the work of this committee are physicians who are also actively and officially interested in the work of the organized medical profession as represented by component county medical societies, constituent state medical associations, and the American Medical Association. . . . "

The Secretary reported for the Executive Committee as follows:

That a motion had been made and passed that the President appoint a committee of five to carry on an annual pre-school health program along lines suggested by a similar committee of the State Medical Society.

That a motion had been made and passed that the President place before the membership at the December meeting, for a vote, the question of transferring the date of the Annual meeting from January 1, 1940 to Monday, January 8, 1940 in view of the fact that the first named date is New Years Day.

That the following slate of officers for the year 1940 had been proposed, to be voted upon at the Annual Meeting:

For President: John G. Walsh, M.D.
For Vice-President: Murray S. Danforth, M.D.
For Secretary: Herman A. Lawson, M.D.
For Treasurer: William P. Davis, M.D.
To Executive Committee, for terms of five years each:
Harry C. Messinger, M.D.
Andrew W. Mahoney, M.D.

Trustee of Rhode Island Medical Library for one year: Charles F. Gormly, M.D.

Delegates to the House of Delegates of the Rhode Island Medical Society: Drs. N. A. Bolotow, J. Franklin, C. Bradley, H. A. Lawson, J. P. Eddy, D. V. Troppoli, M. Adelman, F. Ronchese, A. M. Burgess, G. F. White, M. Saklad, J. A. Hayward, H. C. Messinger, E. W. Bishop, C. L. Southey, H. McCusker, W. P. Buffum, J. Hamilton, J. G. Walsh, M. M. Potter, J. H. Fagan, K. K. Gregory, W. T. Jones, D. Freedman, R. E. Hacking.

Dr. John Dziob, Chairman of the Committee on Credit and Collection, reported briefly on the progress of the work of that Committee.

The Secretary reported that the Executive Committee recommended for election to active membership the following:

George W. Davis, M.D.
Waldo O. Hoey, M.D.
Sarah M. Saklad, M.D.
Malcolm Winkler, M.D.
Catherine Zouraboff, M.D.

On motion of Dr. Jesse Mowry these applicants were unanimously elected to active membership.

The President called upon Dr. Halsey DeWolf who read an obituary tribute to the late Dr. Walter L. Munro. The President called upon Dr. Paul C. Cook who read an obituary tribute to the late Dr. Albert E. Hayes.

The appointment of the following committees was announced by the President: Committee on Pre-School Health Program—Drs. John Langdon, Harold Calder, Frederick Riley, Joseph Smith, and Charles B. Lewis. Committee to prepare an obituary of Dr. George Aloucos—Drs. Antonio D'Angelo and John Vallone. Committee to prepare an obituary of Dr. Alfred McAlpine—Drs. E. A. Shaw and M. J. O'Connor.

On a motion from the floor made by Dr. Jesse Mowry it was voted that the date of the Annual Meeting in 1940 shall be Monday, January 8.

The President introduced as the first speaker, Dr. William M. Muncy, who presented a synopsis of a paper which he had presented before the American Academy of Ophthalmology in Chicago, entitled "Relationship of Tryparsamide Reaction to Vitamin 'B' Deficiency." The paper was discussed by Doctor Hugh Kiene. Dr. Alex M. Burgess then presented "A Case of Prolonged Aleukemic Leukemia." His case report was discussed by Dr. Herman A. Lawson. The scientific program was concluded with the showing of a silent motion picture entitled "Eclampsia."

The meeting adjourned at 10:45 P. M. Attendance 186. Collation was served.

Respectfully submitted,
HERMAN A. LAWSON, M.D., *Secretary*

It is unprofessional to receive remuneration from patents for surgical instruments or medicines; to accept rebates on prescriptions or surgical appliances, or perquisites from attendants who aid in the care of patients.

From the Code of Ethics of the A. M. A.

CASE REPORT

LYMPHATIC LEUKEMIA WITH AN "ALEUKEMIC" STAGE OF UNUSUALLY LONG DURATION

ALEX M. BURGESS, M.D., F.A.C.P.
454 ANGELL STREET, PROVIDENCE

If it is true that lymphatic leukemia is a uniformly fatal disease the statement that the prognosis in leukemia is uniformly bad would seem to be equally true. That this is not so is illustrated by the case here presented. In this instance a woman who developed what was later seen to be the aleukemic stage of the disease lived out the rest of her life, several years beyond her normal life expectancy, and in the end died of lymphatic leukemia in its classic form.

I. B., an unmarried woman, who was seventy-seven years old at the time of her death in February 1939, was first seen by the writer in October 1916 at which time she was a patient of Dr. William McDonald of Providence. In 1914 she had developed intestinal symptoms of a vague nature and was considerably depressed mentally. At that time it was noted that her blood picture showed a high percentage of lymphocytes and leukemia was suspected. She lost weight and later stated to the writer that she was "very ill" for three years.

The first blood examinations of which a record can be found were made in September and October 1915* They showed the following:

September, 1915	
Red cells	4,660,000
Leucocytes	4,200
October 14, 1915	
Leucocytes	3,600
Per cent polynuclears	33.5
Small lymphocytes	55.5
Large lymphocytes	5.5
"Transitionals"	5.5

The patient was first seen by the writer on October 22, 1916 and a blood count on that date showed the following:

Red cells	5,000,000
Leucocytes	3,400
Differential count:	
Polynuclears	40.5 per cent
Lymphocytes	43.5 per cent
Endotheliocytes	5.5 per cent
Eosinophiles	5.5 per cent
Mast cells	1.5 per cent
Transitionals (meta-myocytes)	4. per cent

Presented before the Providence Medical Association, December 4, 1939.

The patient was treated by Dr. William McDonald and was also studied and treated by Dr. A. F. Chace of New York. At some time during these early years, in 1914 or 1915 as far as can be determined, the patient was seen by Dr. David L. Edsall in Boston. The following is quoted from a letter from Dr. Edsall written in response to an inquiry by the writer in April 1938, "I remember her and my thought at the time was that she would develop a leukemia."

There are existing records of 26 blood examinations made between September 1915 and March 5, 1918. These are shown in the accompanying table.

TABLE

	No. of Counts	Leucocytes M	Neutrophiles %	Lymphocytes %	Eosinophiles %	Mast Cells %
1915 to 1918 (Incl.)	26	3.2	26	51	15	4
		13.5	10.5	85	1	0
1926 to 1928 (Incl.)	7	3	33	57	0	3
		6.4	48	40	10	2
1936 to 1938 (Incl.)	12	15.9	29	64	1	1
		164.2	4	95	0.5	0.5

Summary of 45 blood counts—The highest and lowest counts in each of the periods of study is presented.

It was noted that the red count was always in the neighborhood of five million cells and the hemoglobin was in the neighborhood of 90%. Except on two occasions the leucocyte count ranged between 3200 and 7400, the total lymphocyte count varied between 30 and 75 per cent and the polynuclear percentage between 17 and 40.5 per cent. A great preponderance of immature polynuclear cells were noted. The two exceptional counts mentioned were on February 11 and 22, 1915. In these the total leucocytes numbered 13,500 and 12,000 per cubic millimeter with a polynuclear percentage of 10.5 and 16 per cent respectively and in both instances a lymphocyte count of 81 per cent. The average eosinophile count was 4.9% and the highest 15%. Mast cells were seen in most slides and reached 4 per cent in one instance. While the two counts recorded in February 1916 represent a real lymphocytosis it is to be noted that in most of the other records the neutropenia is a most striking finding and the lymphocytosis in most instances is relative rather than absolute. The occasional slight eosinophilia is also notable.

After March 1918 the patient was not seen until October 1926 and during the interval she is said to have enjoyed fair health with still a tendency to abdominal discomfort, "gas" and excessive nervousness. In October 1926 she consulted the writer because of abdominal distress dating in its severe form from the previous August when the patient was on a trip abroad. At this time the patient weighed 110 lbs. (stripped) and gave a history of having weighed 127½ lbs. (clothed) in June 1926, having gradually gained from a low point of 96 lbs. (clothed) in 1914. The general medical history contained no information of importance and the physical examination showed no positive findings except one small scar on the right retina. The blood pressure was 134/80. No enlargement of peripheral lymph nodes or spleen was found on several examinations.

Between October 1926 and March 1928 there is a record of five blood examinations in Providence and two in New York for which I am indebted to Dr. Arthur Freeborn Chace. In these the picture was essentially unchanged. The red count averaged 5,500,000, the hemoglobin 94 per cent, and the total leucocyte count 5,000. The average neutrophile count was 40 per cent and the average lymphocyte count 51 per cent. 10 per cent eosinophiles were noted in one specimen.

During 1926, 1927 and 1928 the patient was treated by Dr. A. F. Chace and by Dr. George L. Shattuck of Providence. In the opinion of Dr. Chace the patient suffered from an intestinal abnormality and the lymphocytosis was to be regarded as a reaction to the toxaemia associated with this condition although he mentioned in a letter the previously expressed opinion of Dr. Edsall that the condition suggested leukemia. Further laboratory studies made during this period include roentgenographic study of gastro-intestinal tract and gall bladder, various chemical studies of the blood, Kahn, Kohlmer, Hinton and Wassermann tests as well as detailed studies of urine and feces. All yielded essentially negative results.

* The writer is indebted to Dr. E. M. Porter of Providence for this and the records of ten subsequent counts made by him up to October 1916, and to Dr. H. A. Lawson for blood studies made in 1936, 1937 and 1938.

From 1928 on the patient was seen occasionally by Dr. George L. Shattuck because of less severe nervous symptoms and on the whole did relatively well without many complaints until 1936 when in October she was seen because of lameness in left knee following a fall. More than a month later she was seen again when she complained of pain and stiffness in both knees and a vague abdominal distress. At this time a blood examination by Dr. F. H. Chafee gave the following results:

Haemoglobin	75%
Red cells	5,020,000
Leucocytes	48,600
Differential:	
Polymorphonuclears	32
Medium lymphocytes	3
Small lymphocytes	53
Monocytes	2
Eosoinophiles	3
Metamyelocytes	6
Basophilicyelocytes	1

Platelets plentiful. Polys. mature. R. B. C. pale.

This indicated a definite hematologic diagnosis of chronic lymphatic leukemia although no symptoms suggestive of the disease may be said to have been present at the time.

From this point on the blood picture remained characteristic as shown in the table. The first definitely enlarged lymph nodes were noted in April 1937 and enlargement of the spleen was not discovered until September of the same year. In March 1938 bleeding from the gums, followed by subcutaneous hemorrhages and hematuria developed. Following X-ray treatment the bleeding disappeared but recurred several weeks later and disappeared again spontaneously. The most uncomfortable symptom was a feeling of great abdominal distress. This was similar to the discomfort for which the patient had been treated ten and twenty years earlier. During the remainder of the year the patient became progressively worse, with marked enlargement of lymph nodes and spleen, occasional periods of bleeding and progressive loss of weight. She died on February 22, 1939, twenty-five years after lymphatic leukemia was suspected, less than three years after the characteristic blood picture of the disease had been discovered and less than two years after symptoms and signs had developed.

A post-mortem examination was performed by Dr. R. J. Williams. The following is a summary of the findings taken from his report.

Primary Lesion:
Lymphatic leukemia.

Secondary or Terminal Lesion:
Splenomegaly.
Generalized lymphadenopathy.
Generalized purpura.
Hemothorax, bilateral, slight.
Hemopericardium, slight.
Generalized leukemic infiltrations with extensive involvement of bone marrow.
Bronchopneumonia.

Comment

The chief interest in this case lies in the fact that in 1914 lymphatic leukemia was predicted from an a-leukemic blood picture, that this picture persisted without symptoms up to 1936 when a blood examination showed the typical findings of the disease, and that the patient did not die until 1939, twenty-five years after the original observations were made. Her life expectancy, as shown by insurance tables, in 1914, when she was 52 years old, was 19½ years. She therefore outlived her expectancy by 5½ years.

It is notable that in all but two of the 33 blood examinations that were made before the actual picture of leukaemia developed there was a relative lymphocytosis only and an actual neutropenia. The leucocytes were noted to be mostly young forms with fairly numerous metamyelocytes. This and the presence of eosinophiles up to 15 per cent and mast cells up to 4 per cent evidenced a definite disturbance of the bone marrow. On two occasions, February 11 and 22, 1916, an actual lymphocytosis was noted and the picture strongly suggested leukaemia.

Following the development of symptoms the average duration of life was shown in a study by Leavell[1] to be 3.6 years and only 4 per cent of the patients whom he studied lived more than 10 years. McGavran[2] has recently reported a case of lymphatic leukaemia of twenty-five years duration in which all counts showed a definite leukemic picture. The longest duration of life reported by Minot and Isaacs[3] was 22 years. In the case here presented the duration of life after the clinical picture developed was less than three years and the interest lies in the long period in which the blood picture though distinctly abnormal was consistently "a-leukaemic."

References

1. Chronic Leukemia—A Study of the Incidence and Factors influencing the Duration of Life. B. S. Leavell. Am. J. Med. Sci. 196:329, Sept. 1938.

2. Lymphatic Leukaemia of Twenty-Five Years Duration. C. W. McGavran. Ann. Int. Med. 12:396, Sept. 1938.

3. Lymphatic Leukemia: Age, Duration and Benefit Derived from Irradiation. Minot & Isaacs. Boston Med. & Surg. Jour. CXCI, 1, 1924.

THE MEMORIAL HOSPITAL
Pawtucket, R. I.

SCHEDULE BEGINNING
FEBRUARY 1, 1940

Medical Service: Medical Ward Rounds at 11:00 A. M. every Saturday. Medical Symposium on the last Friday of each month in the Nurses' Home Auditorium at 11:30 A. M.

Clinical Pathological Conference
February 14, 1940 at 12:00 Noon.

Surgical Service
Surgical Ward Rounds at 11:00 A. M. every Wednesday.

Tumor Clinic
The first and third Thursdays of each month at 10:00 A. M.

Urological Service
Ward Rounds at 12:00 Noon on the first and third Mondays of every month.

Medical Staff Meetings
Meeting of the entire staff on the second Wednesday of each month at 1:00 P. M.

Orthopedic Service
Ward Rounds at 8:30 A. M. every Monday.

Obstetrical Service
Conference on the last Friday of each month, at 12:00 Noon.

Pediatric Service
Ward Rounds and Discussion of Cases at 12:00 Noon every Thursday.

Ear, Nose and Throat Service
Ward Rounds and Discussion of Cases at 10:30 A. M. on the second Wednesday of each month.

Members of the staff and physicians who are not on the staff are cordially invited to participate in the various activities such as ward rounds. The above schedule and subsequent ones will be printed in the JOURNAL so that you may be acquainted with the various dates. If the visiting doctors will present themselves at the Information Desk in the Main Hospital, they will be directed to the various departments.

Marriages: Howard W. Umstead, M.D. to Miss Edith D. Cummings. Jacob Greenstein, M.D. to Miss Bertha Kesslen. Elihu Saklad, M.D. to Sarah Mazick, M.D.

Births: A son to Kathleen M. Barr, M.D. (Langton) A daughter to Raymond E. Stevens, M.D. Twin daughters to Edward H. Trainor, M.D.

The following doctors have completed internships at this hospital this year: Howard W. Umstead, M.D., in November, 1939, and is at present practicing at 425 West Avenue, Pawtucket, R. I. Duncan H. C. Ferguson, Jr., M.D., in November, 1939, and is at present a resident at the State Infirmary, Howard, R. I. William J. O'Connell, M.D., in November, 1939, and is at present an interne in Orthopedics at the Rhode Island Hospital. Kenneth C. vonPohle, M.D., in December, 1939, and is at present practicing in Arizona.

There was a large attendance of doctors at the lecture, illustrated by moving pictures, slides and cases, given by Lawrence Smith, M.D., on the results of hibernation at the Temple University clinic. This was an open meeting and the physicians from all over the state and Southeastern Massachusetts took advantage of this opportunity.

Under the terms of the will of Kenneth F. Wood, formerly connected with the Sayles Industrial Enterprises, the Memorial Hospital has benefited by an unrestricted gift of $100,000.00 The gift is completely unrestricted relative to hospital expenditure above principal interest.

RHODE ISLAND HOSPITAL

On November 30, after an internship of two years, Dr. Howard Ives left for his home in Portland, Maine. On January 1st, Dr. Ives became affiliated with the Mayo Clinic in Rochester, Minn., having obtained a fellowship in Surgery for a period of three years.

On December 31st, Dr. Daniel C. Hackett left the hospital, having served a period of two years as Intern. Dr. Hackett is now at the Willard Parker Hospital in New York City.

On December 15, Dr. Michael DiMaio of Providence, Rhode Island State College and Johns Hopkins Medical School, started a two year's internship. Dr. DiMaio was Intern at the Chapin Hospital from July to December 1939.

On January 10, Dr. William J. O'Connell, of East Providence, became Orthopedic and Fracture Intern. Dr. O'Connell is a graduate of Georgetown University and Tufts Medical School. He served an eighteen month's internship at the Memorial Hospital, Pawtucket.

On January 15, Dr. Herbert Livingston Kehr, of North Bergen, New Jersey, started a two years' internship. Dr. Kehr is a graduate of Cornell University and Columbia University, College of Physicians and Surgeons.

On January 1st, Dr. Dennett Richardson, formerly Superintendent of Chapin Hospital, became Superintendent at the Rhode Island Hospital. Dr. and Mrs. Richardson were welcomed at an informal tea, held at the John M. Peters house Wednesday afternoon, January 10.

OBITUARY

ALFRED FREEMAN McALPINE, M.D.

Alfred Freeman McAlpine, a son of the late Henry and Lavina (Hill) McAlpine, was born in Nova Scotia on April 15, 1893. At an early age he moved with his family to Somerville, Massachusetts, where he received his elementary education. He prepared at the Boston Latin School for Tufts College where he distinguished himself as a student of unusual ability. In 1918, having spent four years at Tufts Medical School, he was graduated with the degree of Doctor of Medicine, magna cum laude.

His hospital training was received at the Rhode Island, the Providence Lying-In, and the Charles V. Chapin hospitals, all in Rhode Island. Because of his keen interest in surgery he spent additional time doing post-graduate work at St. Luke's hospital and at Women's Hospital in New York City. He opened his office in 1920 at 340 Broadway, later moving to 105 Waterman Street where he continued to practice until the time of his death — the result of an automobile accident — on November 9, 1939. McAlpine was an active member of the Urological and Surgical Staffs at the Rhode Island hospital. He served on the Associate Staff at the Homeopathic and the Charles V. Chapin hospitals and in a consulting capacity at the Westerly hospital. He was a member of the Providence Medical Association, the Rhode Island Medical Society, and the American Medical Association. In 1935 he was named a Fellow of the American College of Surgeons. He was also a member of the British Empire Club and the Wannamoisett Country Club. He held the rank of Major of the 315 Cavalry Reserve Officers Medical Corps.

Shortly after his graduation from medical school he was married to Carlotta W. Golini, a classmate at medical school, who survives him, as do his two daughters, Carlotta L., a sophomore at Manhattanville College in New York, and Theodora P., a senior student at Classical High School in Providence. He is also survived by a brother, William E. McAlpine of Somerville, Massachusetts. Another brother, Harold, was killed in action in France on Armistice Day.

Dr. McAlpine's funeral was held from the home of Dr. Golini on November 13, 1939. The Reverend Russell Sturgis Hubbard, rector of St. Martin's Church, officiated and burial was in Carlisle, Massachusetts.

Dr. McAlpine enjoyed an extensive general practice which was undoubtedly a tribute to his ability as a physician as well as to his geniality, kindliness and ever present friendly personality. His death was a shock to his intimate friends and patients for they loved him for what he was — a true friend and kindly doctor.

MICHAEL J. O'CONNOR, M.D.
ELIOT A. SHAW, M.D.

GEORGE JOHN ALOUCOS, M.D.

Dr. George John Aloucos was born at Styra, Greece, forty-one years ago. He attended public school and medical school in his native country and served an internship in a hospital in Greece. He came to this country in 1924. He had already graduated and had served internship when he came to America. With no knowledge of the English language he had many obstacles to surmount but he met them with the same determination he had applied to his medical training. A student of human nature, he enjoyed gatherings, valued acquaintances, and had a faculty of retaining friendships.

Dr. Aloucos served as interne at St. Joseph's Hospital and at hospitals in Springfield, Massachusetts, and Hartford, Connecticut, as well as three months internship at the Bronx Maternity Hospital. He was on the staff of St. Joseph's, Rhode Island and Memorial Hospitals. He was a member of the Providence Medical Association, the Masons of Pawtucket, the Ahepa and the G. A. P. A. Societies, as well as of the Eagles.

On February 12, 1928, Dr. Aloucos was married to Miss Bessie Erinakes. His life closed when he was well on the road to wide recognition. His indomitable courage was assurance that he would have attained heights. The sympathy of all who knew him goes out to his bereaved wife, his eleven year old son, John, and the nine year old daughter, Marie.

JOHN J. VALLONE, M.D.
ANTONIO F. D'ANGELO, M.D.